FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012252

Facility Name: Oak Glen Home

Address: 11210 95th Street, PO Box 430 (Number) Coal Valley (City) 61240 (Zip Code)

County: Rock Island County

Telephone Number: 309-799-3161 **Fax #** 309-799-5904

IDPA ID Number: 36-600-6649-001

Date of Initial License for Current Owners: 9/01/1972

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sheryl Thomas **Telephone Number:** 309-799-3161

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/04 to 11/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Trudy Whittington
(Title) Administrator

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,847	564	3,315	16,726	8
9	SNF/PED					9
10	ICF	37,295	9,392	193	46,880	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,142	9,956	3,508	63,606	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.13%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: 11/30/2005

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	509,730	50,330	18,420	578,480		578,480		578,480			1
2	Food Purchase		417,380		417,380		417,380		417,380			2
3	Housekeeping	230,027	33,139	4,203	267,369		267,369		267,369			3
4	Laundry	192,284	49,898	414	242,596		242,596	(9,284)	233,312			4
5	Heat and Other Utilities			245,358	245,358		245,358		245,358			5
6	Maintenance	238,859	64,647	44,159	347,665		347,665	(33,339)	314,326			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,170,900	615,394	312,554	2,098,848		2,098,848	(42,623)	2,056,225			8
	B. Health Care and Programs											
9	Medical Director					16,000	16,000		16,000			9
10	Nursing and Medical Records	3,196,155	281,721	48,636	3,526,512	(126,876)	3,399,636	(2,251)	3,397,385			10
10a	Therapy	134,744	3,811	396,921	535,476		535,476		535,476			10a
11	Activities					136,507	136,507		136,507			11
12	Social Services	217,130	6,819	94	224,043	(136,507)	87,536		87,536			12
13	CNA Training											13
14	Program Transportation					945	945		945			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,548,029	292,351	445,651	4,286,031	(109,931)	4,176,100	(2,251)	4,173,849			16
	C. General Administration											
17	Administrative					111,950	111,950		111,950			17
18	Directors Fees							6,578	6,578			18
19	Professional Services			1,011	1,011		1,011	379,987	380,998			19
20	Dues, Fees, Subscriptions & Promotions			789	789	24,210	24,999	(23,751)	1,248			20
21	Clerical & General Office Expenses	235,888	8,837	67,306	312,031	(136,160)	175,871		175,871			21
22	Employee Benefits & Payroll Taxes			1,518,273	1,518,273		1,518,273	46,825	1,565,098			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,160	5,160	(945)	4,215		4,215			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*			268,893	268,893		268,893		268,893			27
28	**TOTAL General Administration**	235,888	8,837	1,861,432	2,106,157	(945)	2,105,212	409,639	2,514,851			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,954,817	916,582	2,619,637	8,491,036	(110,876)	8,380,160	364,765	8,744,925			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oak Glen Home #0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			272,043	272,043	(12,972)	259,071	(204,839)	54,232			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							997	997			34
35	Rent-Equipment & Vehicles			63,563	63,563		63,563	(63,563)				35
36	Other (specify):*			16,294	16,294	12,972	29,266	1,313	30,579			36
37	**TOTAL Ownership**			351,900	351,900		351,900	(266,092)	85,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					110,876	110,876		110,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							134,138	134,138			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					110,876	110,876	134,138	245,014			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,954,817	916,582	2,971,537	8,842,936		8,842,936	232,811	9,075,747			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,751)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,078)	MISC		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,829)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*	2,144		32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	437,197		34
35	Other- Attach Schedule	(70,701)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 368,640		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 232,811		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oak Glen Home

ID# 0012252

Report Period Beginning: 12/1/04

Ending: 11/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BARBER AND BEAUTY INCOME	$ (2,251)	10	1
2	OFFICE EQUIP RENTAL INCOME	(63,563)	35	2
3	NONMED NECESS TRANSPORTATION	(5,572)	6	3
4	TRANSPORTATION REVENUE	(2,119)	6	4
5	RENT REVENUE	(25,648)	6	5
6	LAUNDRY REVENUE	(9,284)	4	6
7	DIAPERS	(2,810)	18	7
8	SALE OF JUNK /SALVAGE	(831)	36	8
9	DONATED GOODS	2,144	36	9
10	DEPRECIATION ADD ON	862	30	10
11	PARTICIPATION FEE ADJ FOR BED TAX	134,138	42	11
12	DEPRECIATION EXP ADJ	(205,701)	30	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(180,635)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Oak Glen Home **# 0012252** **Report Period Beginning: 12/1/04** **Ending: 11/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9,284)	0	0	0	0	0	0	0	0	0	0	(9,284)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(33,339)	0	0	0	0	0	0	0	0	0	0	(33,339)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(42,623)	0	0	0	0	0	0	0	0	0	0	(42,623)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,251)	0	0	0	0	0	0	0	0	0	0	(2,251)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,251)	0	0	0	0	0	0	0	0	0	0	(2,251)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	(2,810)	9,388	0	0	0	0	0	0	0	0	0	6,578	18
19	Professional Services	0	379,986	0	0	0	0	0	0	0	0	0	379,986	19
20	Fees, Subscriptions & Promotions	(23,751)	0	0	0	0	0	0	0	0	0	0	(23,751)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	46,824	0	0	0	0	0	0	0	0	0	46,824	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,561)	436,198	0	0	0	0	0	0	0	0	0	409,637	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,435)	436,198	0	0	0	0	0	0	0	0	0	364,763	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Oak Glen Home **#** 0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(204,839)	0	0	0	0	0	0	0	0	0	0	(204,839)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	997	0	0	0	0	0	0	0	0	0	997	34
35	Rent-Equipment & Vehicles	(63,563)	0	0	0	0	0	0	0	0	0	0	(63,563)	35
36	Other (specify):*	1,313	0	0	0	0	0	0	0	0	0	0	1,313	36
37	**TOTAL Ownership**	(267,089)	997	0	0	0	0	0	0	0	0	0	(266,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	134,138	0	0	0	0	0	0	0	0	0	0	134,138	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	134,138	0	0	0	0	0	0	0	0	0	0	134,138	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(204,386)	437,195	0	0	0	0	0	0	0	0	0	232,809	45

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rock Island County	100	Oak Glen Home	Coal Valley			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		18	Welfare Committee	$	Rock Island County	100.00%	$ 9,388	$ 9,388	1
2	V		19	Risk Management		Rock Island County	100.00%	176,795	176,795	2
3	V		19	General Management		Rock Island County	100.00%	35,621	35,621	3
4	V		19	Auditor		Rock Island County	100.00%	16,574	16,574	4
5	V		19	Purchasing		Rock Island County	100.00%	5,900	5,900	5
6	V		34	County Buildings		Rock Island County	100.00%	997	997	6
7	V		19	Information Systems		Rock Island County	100.00%	39,616	39,616	7
8	V		19	Treasurer		Rock Island County	100.00%	277	277	8
9	V		19	County Board		Rock Island County	100.00%	105,203	105,203	9
10	V		19	States Attorney/County Clerk		Rock Island County	100.00%			10
11	V		26	Property Insurance		Rock Island County	100.00%			11
12	V		22	Worker's Comp		Rock Island County	100.00%	45,429	45,429	12
13	V		22	Unemployment Comp		Rock Island County	100.00%	1,395	1,395	13
14	Total				$			$ 437,195	$ * 437,195	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CALVILLO	CHAIR, NUR HM C	DIRECTOR					SALARY	$ 1,615	18	1
2	BALLARD	NURS HM COMM	DIRECTOR					SALARY	808	18	2
3	ELLIS	NURS HM COMM	DIRECTOR					SALARY	1,514	18	3
4	JACOBS	NURS HM COMM	DIRECTOR					SALARY	1,211	18	4
5	MARANDA	NURS HM COMM	DIRECTOR					SALARY	1,211	18	5
6	MEERSMAN	NURS HM COMM	DIRECTOR					SALARY	1,514	18	6
7	PEREZ	NURS HM COMM	DIRECTOR					SALARY	1,514	18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,387		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Committee	Cost Allocation Study	100		$ 9,388	$	100	$ 9,388	1
2	19	Risk Management	Cost Allocation Study	100		176,795		100	176,795	2
3	19	General Management	Cost Allocation Study	100		35,621		100	35,621	3
4	19	Auditor	Cost Allocation Study	100		16,574		100	16,574	4
5	19	Purchasing	Cost Allocation Study	100		5,900		100	5,900	5
6	34	County Buildings	Cost Allocation Study	100		997		100	997	6
7	19	Information Systems	Cost Allocation Study	100		39,616		100	39,616	7
8	19	Treasurer	Cost Allocation Study	100		277		100	277	8
9	19	County Board	Cost Allocation Study	100		105,203		100	105,203	9
10	19	States Attorney/County Clerk	Cost Allocation Study	100				100	0	10
11	26	Property Insurance	Cost Allocation Study	100				100	0	11
12	22	Worker's Comp	Actual Cost	100		45,429		100	45,429	12
13	22	Unemployment Comp	Actual Cost	100		1,395		100	1,395	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 437,195	$		$ 437,195	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Oak Glen Home **#** 0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Glen Home COUNTY Rock Island County

FACILITY IDPH LICENSE NUMBER 0012252

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,498 B. General Construction Type: Exterior BRICK Frame Block & Brick Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	OPERATIONS	280 Acres	1917	$ 18,526	1
2					2
3	TOTALS	#VALUE!		$ 18,526	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1954	1954	$ 436,798	$		$	$	$ 436,798	4
5			1966	1966	3,438					3,438	5
6			1967	1967	601,561					601,561	6
7			1969	1969	176,656					176,656	7
8			1972	1972	20,431					20,431	8
	Improvement Type**										
9				1969	174,960					174,960	9
10				1984	84,571	3,384	25	3,384		72,649	10
11				1985	37,530	1,719	VARI	1,719		37,530	11
12				1986	6,350	318	VARI	318		6,192	12
13				1987	36,101	671	VARI	671		35,037	13
14				1989	22,670	907	25	907		14,585	14
15				1990	16,161	808	20	808		12,256	15
16				1992	6,989	350	20	350		4,572	16
17				1993	16,131	807	VARI	807		10,216	17
18				1995	59,404	2,970	VARI	2,970		30,914	18
19				1997	14,800	740	VARI	740		6,177	19
20				1998	106,570	1,829	VARI	1,829		83,406	20
21	Driveway and Sidewalks			1999	22,375	2,797	8	2,797		17,247	21
22	Gutters and boiler stack			2003	58,868	5,342	VARI	5,342		13,220	22
23	New roof on boiler room			2004	25,970	2,600	10	2,600		3,973	23
24	Stair railing renovation			2005	34,069	1,522	15	1,522		1,522	24
25	Pella windows			2005	36,425	1,020	15	1,020		1,020	25
26	Renovation work for Alzheimer unit			2005	183,040	3,051	15	3,051		3,051	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,181,868	$ 30,835		$ 30,835	$	$ 1,767,411	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 126,395	$ 11,512	$ 11,512	$	VARIOUS	$ 59,045	71
72	Current Year Purchases					VARIOUS		72
73	Fully Depreciated Assets	372,028				VARIOUS	372,028	73
74	Variance		3	3		VARIOUS		74
75	TOTALS	$ 498,423	$ 11,515	$ 11,515	$		$ 431,073	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT CARE	2002 CHEVY TRUCK	2001	$ 26,111	$ 5,223	$ 5,223	$	5	$ 20,889	76
77	PATIENT CARE	CHEVY MINIVAN	2003	33,295	6,659	6,659		5	15,538	77
78										78
79										79
80	TOTALS			$ 59,406	$ 11,882	$ 11,882	$		$ 36,427	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,758,223	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,232	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,232	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,234,911	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,COL 6	# of prescrpts	110,876					110,876	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 110,876		$	$		$ 110,876	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,114	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	140,025		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,890,116		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,744		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	655,510		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,688,509	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,688,509	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 281,021	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	400		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,889		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO OTHER FUNDS	83,920		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 522,230	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 522,230	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,166,279	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,688,509	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Oak Glen Home **#** 0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,326,904	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,326,904	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(160,625)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (160,625)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,166,279	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,955,947	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,955,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,837	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,251	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,648	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	6,861	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,119	21
22	Laundry	9,284	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 48,000	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58,899	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,899	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	JUNK SALE	831	28
28a	TAX LEVY	1,618,635	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,619,466	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,682,312	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	8,842,936	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,842,936	40
41	**Income before Income Taxes (line 30 minus line 40)****	(160,624)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (160,624)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,666	2,088	$ 48,744	$ 23.34	1
2	Assistant Director of Nursing	1,775	2,137	47,065	22.02	2
3	Registered Nurses	15,153	17,019	338,559	19.89	3
4	Licensed Practical Nurses	56,471	63,073	1,013,612	16.07	4
5	CNAs & Orderlies	136,119	154,032	1,721,167	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,664	8,408	134,053	15.94	8
9	Activity Director	1,806	2,142	42,664	19.92	9
10	Activity Assistants	6,525	7,784	93,843	12.06	10
11	Social Service Workers	4,971	5,721	80,720	14.11	11
12	Dietician					12
13	Food Service Supervisor	3,422	4,205	68,487	16.29	13
14	Head Cook	7,803	9,092	117,469	12.92	14
15	Cook Helpers/Assistants	5,941	6,853	74,649	10.89	15
16	Dishwashers	22,352	24,768	248,489	10.03	16
17	Maintenance Workers	11,137	13,856	239,323	17.27	17
18	Housekeepers	15,974	19,318	227,823	11.79	18
19	Laundry	14,070	16,566	196,614	11.87	19
20	Administrator	1,849	2,088	61,500	29.45	20
21	Assistant Administrator	1,627	2,088	50,450	24.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,674	9,687	125,366	12.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,807	3,080	37,955	12.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	326,806	374,005	$ 4,968,552 *	$ 13.28	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	502	$ 16,064	L1 C3	35
36	Medical Director	12 Months	16,000	L9 C5	36
37	Medical Records Consultant	0	0	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 Months	1,140	L10 C3	39
40	Physical Therapy Consultant	2,483	136,195	L10a C3	40
41	Occupational Therapy Consultant	3,143	163,848	L10a C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,164	78,688	L10a C3	43
44	Activity Consultant	13	829	L12 C3	44
45	Social Service Consultant				45
46	Other(specify) LAB	12 Months	6,749	L10 C3	46
47	RADIOLOGY	12 Months	640	L10 C3	47
48	ORTHO & RHEUM	12 Months	1,030	L10 C3	48
49	TOTAL (lines 35 - 48)	7,305	$ 421,183		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittingron	Administrator		$ 61,500
Sheryl Thomas	Asst. Administrator		50,450
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,950

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Ramirez Consulting		$ 293
Ramirez Consulting		260
Ramirez Consulting		276
Ramirez Consulting		182
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 1,011

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,429
Unemployment Compensation Insurance	1,395
FICA Taxes	366,595
Employee Health Insurance	754,670
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	397,008
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,565,097

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,912
Health Care Worker Background Check	
(Indicate # of checks performed)	
NAEIR Dues & Fees	789
Subscriptions, Dues, & Fees	2,298
Less: Public Relations Expense	( )
Non-allowable advertising	(23,751)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,248

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,050
Seminar Expense	3,165
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,215

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/04 Ending: 11/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/1/04 **Ending:** 11/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **1690**
If YES, give association name and amount. **COUNTY NURSING HOME ASSOC**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,846** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **1,979**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.